

Personal History (Adult)

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

- Anger management Anxiety Coping Depression
 Eating disorder Fear/phobias Mental confusion Sexual concerns
 Sleeping problems Addictive behaviors Alcohol/drugs
 Other mental health concerns (specify): _____

Current Health Conditions (please specify history of illness):

Duration of Current Issues:

Is this treatment/counseling court ordered? ___yes ___no

Medical/Physical Health

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Colds/Coughs | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Vomiting |

Dental problems Miscarriages Whooping cough
 Diabetes Neurological disorders Other (describe): _____
 Diarrhea Nausea _____

List any recent health or physical changes: _____

Does you have any know allergies or medical conditions? If so, what are they? _____

How would you describe your overall health? fair poor average

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Lunch	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Dinner	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Snacks	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High

Comments: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? Yes No

If Yes, describe: _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____

Upcoming surgery _____

Family history of medical problems: _____

Please check if there have been any recent changes in the following:

Sleep patterns Eating patterns Behavior Energy level
 Physical activity level General disposition Weight Nervousness/tension

Describe changes in areas in which you checked above: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
					_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____	_____	_____	
Barbiturates	_____	_____	_____	_____	_____	_____	_____	
Valium/Librium	_____	_____	_____	_____	_____	_____	_____	
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____	
Marijuana	_____	_____	_____	_____	_____	_____	_____	
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____	
Inhalants	_____	_____	_____	_____	_____	_____	_____	
Caffeine	_____	_____	_____	_____	_____	_____	_____	
Nicotine	_____	_____	_____	_____	_____	_____	_____	
Over the counter	_____	_____	_____	_____	_____	_____	_____	
Prescription drugs	_____	_____	_____	_____	_____	_____	_____	
Other drugs	_____	_____	_____	_____	_____	_____	_____	

Substance of preference

1. _____
2. _____
3. _____
4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:

Addicted Build confidence Escape Self-medication
 Socialization Taste Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Does your body temperature change when you drink? Yes No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? Yes No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Development

Are there special, unusual, or traumatic circumstances that affected your development? Yes No

If Yes, please describe: _____

Has there been history of child abuse? Yes No

Parental Information

Parents legally married Mother remarried: Number of times: _____

Parents have ever been separated Father remarried: Number of times: _____

Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower

Friendly Leader Outgoing Shy/withdrawn Submissive

Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? Yes No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? Yes No

If Yes, describe: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If Yes, describe: _____

Were you raised within a spiritual or religious group? Yes No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ___ Yes ___ No

If Yes, describe: _____

Marital Status (more than one answer may apply)

___ Single ___ Divorce in process ___ Unmarried, living together

Length of time: _____ Length of time: _____

___ Legally married ___ Separated ___ Divorced

Length of time: _____ Length of time: _____ Length of time: _____

___ Widowed ___ Annulment

Length of time: _____ Length of time: _____ Total number of marriages: ___

Assessment of current relationship (if applicable): ___ Good ___ Fair ___ Poor

Military

Military experience? ___ Yes ___ No Combat experience? ___ Yes ___ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? ___ Yes ___ No

If Yes, please describe: _____

Past History

Traffic violations: ___ Yes ___ No DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement: ___ Yes ___ No Civil involvement: ___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? Yes No
If Yes, explain: _____

For Staff Use

Therapist's signature/credentials: _____ Date: ____/____/____

Supervisor's comments: _____

_____ Physical exam: ___ Required ___ Not required

Supervisor's signature/credentials: _____ Date: ____/____/____

(Certifies case assignment, level of care and need for exam)